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FILED APR 7 1944

State File No. _____

Registration District No. 243

Primary Registration District No. 3047

Registrar's No. 27

1. PLACE OF DEATH:

(a) County NEWTON

(b) City or town NEOSHO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: SALE MEMORIAL HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEWTON

(c) City or town NEOSHO
(If outside city or town limits, write "RURAL")

(d) Street No. 339 W. MECORD
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FRED A. BOWEN

3. (b) If veteran, name war NONE

3. (c) Social Security No. 426-07-0414

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 11 year 1944 hour 12:15 minute P. M.

21. I hereby certify that I attended the deceased from March 17 1944 to March 11 1944 and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JULIA M. BOWEN

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased MAY 30 1880
(Month) (Day) (Year)

Immediate cause of death acute nephritis with uremia Duration _____

Due to acute cholecystitis with blockage of common duct

Due to Arterio-sclerosis

8. AGE: Years Months Days If less than one day

63 9 11 hr. min.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

9. Birthplace WELSH SETTLEMENT PENN 1
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED MACHINIST

11. Industry or business PET MILK CO.

12. Name WILLIAM BOWEN

13. Birthplace PENN. 1
(City, town, or county) (State or foreign country)

14. Maiden name ELSIE WEBSTER

15. Birthplace PENN 1
(City, town, or county) (State or foreign country)

16. (a) Informant Edward W. Bowen

(b) Address Silver Springs Ark

17. (a) Burial (b) Date thereof 3-13-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Neosho 2nd Cem.

18. (a) Signature of funeral director Wiley Thompson

(b) Address Neosho Mo.

19. (a) 3-25-1944 (b) Wiley Thompson
(Date received local registrar) (Registrar's signature)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____

23. Signature Helena C. Burman (M. D. or other) MD
Address Neosho, Mo Date signed 3-25-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 13 1948

RECEIVED

District Health Officer No. 4/5/44

District File Number 444-62

Date Filed 4/6/44

STATEMENT BY LICENSED EMBALMER.

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Barley Thompson

Licensed Embalmer No. 3259

P. O. Address. Neosho Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 243

Primary Registration District No. 3047

1. PLACE OF DEATH:

(a) County Newton
 (b) City or town Neosho
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Fred A. Bowers

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ (Years)

7. Birth date of deceased may 30
 (Month) (Day) (Year)

8. AGE: Years 63 Months 9 Days _____ (if less than one day) _____ min.

9. Birthplace Penn.
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
 13. Birthplace (City, town, or county) (State or foreign country)

{ 14. Maiden name _____
 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
 that I last saw him _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death acute nephritis
both pre- & post-
acute cholecystitis with
blockage of common
duct.
 Due to _____
 Due to arteriosclerosis
chronic interstitial nephritis
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)
 (a) Means of injury _____
 23. Signature Melvin C. Bowman (M. D. or other) M.D.
 Address Neosho, Mo. Date signed 4-15-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

11603

FEB 1 1945